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ABSTRACT

Mental health professionals and the general public have generally held differing attitudes toward mental illness. As part of a needs assessment survey, 102 persons (20 service providers, 20 referral persons, and 62 potential consumers) were interviewed concerning their views of mental health problems and services. Respondents first listed examples of problems existing in their community and then judged the similarity between problems on the comprehensive list. Multidimensional scaling techniques indicated that each of the groups was organizing its thinking about mental health problems along three dimensions: personal, institutional, and chronological. The dimensions were weighted differently by each of the three groups. Service providers placed more emphasis on the 'personal' dimension, potential consumers on the 'institutional' dimension, and referral persons on the 'chronological' dimension. While the groups seemed to have common grounds for communication about mental health issues, they appeared to disagree about priorities in mental health planning. (Author/BMW)

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Views of Mental Health
A First Step in Needs Assessment

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Views of Mental Health: A First Step in Needs Assessment

Mental health professionals and the general public have been shown to hold differing attitudes toward mental illness (Rabkin, 1972). Further, it is clear that an understanding of community perceptions of mental health problems is necessary in order to provide relevant and responsive mental health services. As Turner et. al. (1977) point out, "without assessment (of community attitudes) some centers may create lacunae within the community by designing and delivering services to select socioeconomic groups or to select age groups (p. 225)". The issue of community views is important not only for planning needed services, but also for evaluating how services are used and how they meet the expectations of community residents. McKirnan (1978) notes that community views not only influenced how the "deviant" individual is defined by self and others, but also have "direct bearing on our understanding of why some individuals approach or fail to approach treatment sources (p. 225)".

Attempts to investigate areas of concern in the lives of community residents have indicated two important issues. First, people report "life crises" as causing great stress, but they may not necessarily consider these to be mental health issues. It has been shown that nurses and aides have conceptions of mental illness which differ from those of psychologists, psychiatrists, and social workers (Rabkin, 1972). Thus it may seem reasonable to expect that community residents' definitions of problem areas will not coincide with the viewpoints of mental health professionals. Secondly, people turn to a variety of sources for help. Turner et. al. (1977) found that community mental health centers ranked fourth as a potential source of help, trailing friends, physicians, pastors, and teachers. Helpers other than the

traditional providers of mental health service appear to be viewed as tremendously important in the functioning of the service network by potential consumers (Eddy, Paap & Glad, 1970; McWilliams & Morris, 1974).

The present paper is a report of the first phase of a needs assessment survey conducted in Butler County, Ohio. The intent of any such survey is to carry out a "research and planning activity designed to determine a community's mental health service needs (Warheit, Bell and Schwab, 1977)". Because conceptions of mental health issues may differ, preparation of needs assessment approaches must be particularly sensitive to bias. Assessment of community needs should be designed in a manner that is consistent with community definitions, rather than staff prescriptions for mental health. As Siegel, Attkisson & Cohn (1977) have noted, thorough needs assessment "helps assure that there will be additional inputs to balance staff formulations of service needs and to buffer an overwhelming influence from a single vocal or powerful community group (p. 46)". Advisory boards have traditionally functioned to provide community input into survey instruments, but it should be pointed out that these persons have been "professionalized" by their involvement in the existing mental health network. In addition, they are most frequently in the position of "responding to" plans, rather than being actively involved in their construction (Siegel, et. al., 1977). This process of "professionalized" assessment tends to maintain existing programs and inhibit innovative change.

There are three major approaches to the task of needs assessment: social and health indicator analysis, social area surveys, and community group approaches. The indicator approaches depend on making inferences about mental health needs based on descriptive statistics (such as area demography, location relative to the "urban core", arrest rates, etc.) (Bloom, 1975; Siegel et. al., 1977). Such methods depend heavily on previously demonstrated

correlations, but reveal little about how community people view these issues, or feel about them.

Social area surveys deal more directly with community views. Siegel et. al. (1978) describe three types of social area surveys: demands for service, analysis of service resources, and citizen surveys. The first two methods deal with existing services, data about them and about persons who have come into contact with them. However, as Bell et. al. (1978) have noted, the weakness of these approaches is "the assumption that needs for services are accurately expressed by demands for service (p. 261)". Citizen surveys, on the other hand, assess directly individual community resident's perspectives of mental health needs.

Community group approaches also attempt to assess resident perspectives directly by means of community forums, group meetings, or interaction with "key informants". These groups and informants are usually selected for being "in the know" enough to serve as spokespersons for the community.

The present paper reports on the first step of a citizen survey needs assessment. The citizen survey was requested by the local Mental Health Board to complement existing social area and demographic data in their planning process. Because of concern with professional bias in the structuring of such a survey, the present investigators began by asking community groups, referral persons, and mental health practitioners to respond to open-ended questions concerning community problem areas. Once a lexicon of mental health issues had been established, a face-to-face interview was carried out to focus more specifically on mental health problems and services. Three groups of subjects were asked to respond to this interview: mental health practitioners, mental health referral persons, and potential consumers. The primary goal was to determine a shared conception of what was meant by

"mental health". Only when this question was answered could the citizen survey be constructed with confidence. The present paper is concerned with similarities and differences among the three groups in: a) their perceptions of mental health issues, b) the kinds of behaviors seen as constituting mental health problems, and c) the kinds of services which might be identified as most helpful or effective.

Method

Overview

Perceptions of mental health problems and issues were assessed in a two phase study. In the first phase, respondents listed examples of problems existing in their community. A comprehensive list of the most frequent responses was compiled. In the second phase, mental health service providers, mental health referral persons, and potential consumers of mental health services were asked to judge the similarity between the problems appearing on the comprehensive list. The three groups of respondents were compared based on these judgments.

Phase 1

A comprehensive list of the most frequently cited community problems was obtained by asking community residents to respond to an open-ended questionnaire. Seventeen mental health practitioners (psychologists, psychiatrists, community mental health center staff), 15 mental health referral persons (physicians, clergy, social workers, lawyers, educators), and 96 potential consumers (persons unrelated to the delivery or referral of mental health services or other "helping" professions) answered this questionnaire. Respondents provided three to five examples of each of the following:

- problems in living or life crises.
- unacceptable, unusual or inappropriate behavior.
- reasons why someone might seek help from some kind of mental health service.
- types of service one might expect to obtain from a mental health center.

Phase 2

Subjects. Twenty service providers, twenty referral persons, and sixty-two potential consumers (30 male and 32 female) were individually interviewed. Potential consumers were selected to obtain a county-wide representation from major urban and rural areas. They ranged in age from 21 to 78 years with a median age of 36.5 years. Thirty-six percent of the consumer sample earned under the median income for the county. The consumer sample approximated the racial and geographic (rural, small town, urban) distribution of the county. All respondents were different from those who answered the Phase 1 questionnaire, and all were residents or (in the case of providers and referral persons) employed in the target county.

Procedure. Each interview took approximately one hour and was conducted in the respondent's home or place of work. Five graduate and undergraduate students acted as interviewers. Respondents were given a stack of cards each labelled with one of the 54 most frequently cited mental health problems (obtained in Phase 1). Each respondent was then instructed:

This stack of cards contains problem issues named by a sample of Butler County consumers, referral persons and mental health providers. Please sort these cards into groups of problems, putting together those items which seem to you to be most similar. Make each group as homogenous as possible. You may have single card categories if you wish, and you may place an item in more than one category by asking me for a blank duplicate.

After the similarity sort, subjects were asked to label their five largest groupings of problems. Participants then responded to a series of questions

concerning the problem groups and their importance within the target county.

In a similar manner, respondents judged the similarity between the 28 most frequently cited types of mental health services from Phase 1, and labeled the five largest groups.

Results

The results reported here are concerned only with the three subject groups' responses to the request for similarity sorts of mental health problems. Results concerning mental health services are reported in a separate paper (Vess & Saneda, 1979). Responses to specific questions concerning problems and services are currently under analysis.

Distance measures.

The perceived similarity-dissimilarity between the 54 instances of mental health problems was estimated by computing Rosenberg Profile Distance Measures (RPDMs) from the results of individual similarity sorts (Rosenberg and Kim, 1975). The RPDMs were computed separately for each group of respondents. The RPDM between any two mental health problem instances is based on the proportion of times that the respondents of a given group placed the problem instances in different categories during the similarity sort. Thus, if respondents always included two instances in the same category, the RPDM would be zero, suggesting that the two instances are judged to be highly similar. High values of the RPDM occur if two problem instances are rarely or never included in the same category by respondents of a specific subject group. In this manner, the RPDMs quantify perceived similarity-dissimilarity based on the data from the card sorting task.

Multidimensional scaling of aggregate data.

The matrices of the RPDMs (one for each group of respondents) were submitted to an individual difference, nonmetric, multidimensional scaling analysis (Takane et. al, 1977). This analysis assumes that the three groups of respondents judged the similarity-dissimilarity of the mental health problems along a set of common dimensions, although it does allow for differential weighting of these common dimensions for each group. Differential weighting of dimensions would occur if a dimension was more salient or important in one group's judgment than for the other group's judgments. Inspection of the stress values as a function of the number of stimulus dimensions (Table 1) suggests that three stimulus dimensions adequately account for the similarity judgments of the three groups. That is, using more dimensions does not greatly enhance the adequacy of the solution, and using fewer dimensions does not adequately account for the data; therefore, a three-dimensional solution was chosen.

Identification of problem dimensions.

Figure 1 is a schematic representation of the location of clusters of selected problems along the three dimensions that emerged from the individual difference multidimensional scaling analysis. Inspection of the ordering or problem types along the dimensions suggests the following labels for those dimensions:

- a) PERSONAL - locus of the problem ranging from interpersonal (e.g., inability to adjust in society) to intrapsychic (e.g., emotional adjustment).
- b) INSTITUTIONAL - size of the societal institutions most directly affected by the problems, ranging from micro-structure (e.g., individual or family) to macro-structure (e.g., community or society).
- c) CHRONOLOGICAL - the age group most directly associated with the problem, ranging from conception to old age.

Although the similarity-dissimilarity data for the three subject groups seems to be adequately represented by the three common dimensions, the dimensions were weighted differentially by the three groups (see Table 2). The service providers and potential consumers weight the PERSONAL and INSTITUTIONAL dimensions most heavily, with service providers giving relatively more weight to the PERSONAL dimension, and the potential consumers giving relatively more weight to the INSTITUTIONAL dimension. In contrast, the referral persons most strongly emphasize the CHRONOLOGICAL dimension, giving very little weight to the PERSONAL and INSTITUTIONAL dimensions. Thus, the results of the individual difference multidimensional scaling solution suggests that the three groups perceive the similarity-dissimilarity of problems in terms of three common dimensions, but that the three groups differ in the subjective importance attached to the dimensions of similarity of mental health problems.

Separate multidimensional scaling for each respondent group.

Since the individual difference multidimensional scaling procedure begins with the assumption that the three groups are using common dimensions and attempts to find a solution consisting of such common dimensions, it was deemed desirable to provide an independent assessment of this assumption by submitting the data from each group to separate multidimensional scaling analyses. These separate analyses were conducted to answer two questions: a) would three dimensions emerge from each group's data, and b) if a three dimensional solution seemed the most appropriate for each group, would the three dimensions be the same for all three groups? To this end, the RPDMS from each group were input separately into a nonmetric multidimensional scaling analysis (Takane et. al., 1977). In Figure 2, stress values from the analysis of each group's data are plotted by the number of dimensions used.

Based on stability (stress), parsimony and interpretability (Shephard et. al., 1972), a three-dimensional solution was judged to be an appropriate representation of the data for each group.

To determine the degree of commonality between the dimensions obtained in the separate analyses, correlations between the coordinate values for the 54 problems on each dimension for each group were computed. A high correlation between a dimension from one group's scaling solution and a dimension of another group's scaling solution would occur if the 54 problems were arranged in similar ordering and spacing along the two dimensions; thus, a high correlation would imply that the two dimensions were essentially the same for the two groups. In like manner, a low correlation between a dimension from one group's solution and a dimension from another group's solution would occur if the problems were ordered and/or spaced differentially on the two dimensions; thus, a low correlation would imply that the two dimensions were conceptually different. Since the multidimensional scaling procedure used results in orthogonal dimensions within any one analysis, correlations between the three dimensions for a particular group would be low. In sum, if the same three orthogonal dimensions were obtained for each group, a dimension from one group's analysis would correlate highly with one and only one dimension from each of the other group's analyses. The pattern of correlations obtained in Table 3 suggests that, in fact, the separate multidimensional scaling analyses resulted in very similar dimensions for the three groups. That is, each dimension from one group correlated highly with only one dimension obtained for each of the other two groups.

Sufficient evidence exists to conclude that the three groups were using common dimensions in judging the similarity-dissimilarity of the mental health problems. Also, practitioners and potential consumers weighted all three

dimensions similarly, while referral persons attached considerably more weight to the CHRONOLOGICAL dimension.

Discussion

Results of the multidimensional scaling analysis of interview responses indicate that mental health service providers, referral persons and potential consumers share a conception of mental health problems. This conception is organized around three dimensions. The three groups differ, however, on which dimension they emphasize most heavily. This suggests that, while they seem to have common grounds for communication about mental health issues, these groups may well disagree about priorities in mental health planning.

The three shared dimensions have been labelled PERSONAL, INSTITUTIONAL, and CHRONOLOGICAL (refer back to Figure 2). The PERSONAL dimension encompasses those problems which relate to the individual, ranging from interactional or interpersonal problems (crimes committed, problems arising out of divergent moral standards) to internal or intrapsychic problems (depression, anxiety). The INSTITUTIONAL dimension relates to the size of social group involved in the problem, ranging from micro-structure (small groups, individual, family) to macro-structure (larger systems such as the community-at-large). The CHRONOLOGICAL dimension refers simply to the age of persons involved in the problems, ranging from conception (including problems of unwanted pregnancy or abortion) to old age (problems of the elderly, death and dying).

Service providers and potential consumers appear to most nearly share a view of mental health. These two groups place most emphasis on the PERSONAL and INDIVIDUAL dimensions and very little weight on the CHRONOLOGICAL dimension. There does appear, however, to be a trend for the service providers to use the PERSONAL dimension to order their conceptions of mental health problems.

while consumers seem to more heavily emphasize the INSTITUTIONAL dimension. The referral persons are most divergent as a group, in that they acknowledge the other dimensions, but almost exclusively weight the CHRONOLOGICAL dimension.

This difference in viewpoint would appear to have serious implications for communication within the human services network. Emphasis on different dimensions would lead one to make different assumptions about such things as: locus of the problem, causality, optimal time, place and type of intervention, sources of funding, and planning of future services. Certainly, when one thinks of the organization of services and sources of funding, the CHRONOLOGICAL dimension emerges as important. Hospital services divide into obstetrics, pediatrics, adolescent units, and geriatrics. The court system separates juvenile and adult offenses, and most of the available federal funding is organized by age of recipients. The use of age is clearly administratively convenient. One hardly needs complicated diagnostic tests or sociological analyses to distinguish infants from senior citizens. On the other hand, practitioners and consumers would appear to agree that such distinctions give little qualitative information about the mental health problems under consideration. Whether the age stratification of services has caused referral views, or is a result of such emphasis, remains to be seen.

In the meantime, referral persons (physicians, teachers, lawyers, clergy) are acting as "middle men" between consumers and providers. If their notion of the organization of mental health problems is primarily age related, it seems likely that their assessment of a given individual's service need will be based on that dimension. An elderly person complaining of listlessness and depression will then be more likely to be evaluated by a referral person as having a problem related to old age. The most likely search for an appropriate

referral will then be among services for the elderly. A mental health practitioner, however, who sees the same individual, may focus on the personal, intrapsychic problem of depression which happens to be manifested in a person who is elderly. If we can be allowed to stretch our speculation even further, it seems possible that, while the consumer may be in relative agreement with the provider, the consumer will still be more inclined to look for societal relationships (INSTITUTIONAL dimension) of the depression, such as inadequate income, transportation, or housing.

The referral path of specific problems, the "satisfaction" of participants with services received, and evaluation of the "appropriateness" of the referral, would all seem likely to be affected. Inquiry into the relationship between different emphasis on the three dimensions of mental health problems, and how these influence decisions regarding individual clients is an area which demands further research.

It would seem that if mental health information materials were organized to present all community services in a chronological framework, even if some of the services do not use an age criterion, referral persons might be assisted in making appropriate problem/service matches. In-service training enterprises could also assist in making the expectations and assessments of referral persons more congruent with those of consumers and providers. While these efforts may appear to be repetative and redundant, increasing the probability that people in need of mental health service are assisted in obtaining services that both meet their expectations and are deemed appropriate by the mental health practitioner, would greatly enhance the efficiency of the mental health delivery system.

The concern with "professional bias" on a consumer survey in Butler County was the impetus for this analysis of interview responses. The strong

agreement between consumer and providers of mental health services increases confidence that the questionnaire and respondents in the citizen survey will share a framework for inquiry. Making decisions about priorities for mental health planning based on the survey responses will be enhanced by involving representatives of all three interest groups. Using increased understanding derived from the present study to assist in "translating" misunderstood priorities may assist in maximizing the opportunity for innovative and responsive mental health planning.

TABLE 1

Stress values as a function of the number of stimulus dimensions for the individual difference scaling solution.

DIMENSION	1	2	3	4
STRESS	.597	.246	.198	.179

TABLE 2

Subject weights for each stimulus of the 3-Dimensional individual differences scaling solution.

	WEIGHT PERSONAL	WEIGHT INSTITUTIONAL	WEIGHT CHRONOLOGICAL
CONSUMER	.6616	.7172	.1130
PROVIDER	.8671	.4522	.081
REFERRAL	.2652	.2047	.8875

TABLE 3

Correlations between the coordinate values of problems on the three dimensions for consumer, provider and referral groups.

	CONSUMER CHRONOLOGICAL	CONSUMER MACRO/MICROSOCIAL	CONSUMER INTRA/INTERPSYCHIC	REFERRAL CHRONOLOGICAL	REFERRAL MACRO/MICROSOCIAL	REFERRAL INTRA/INTERPSYCHIC	PROVIDER CHRONOLOGICAL	PROVIDER MACRO/MICROSOCIAL	PROVIDER INTRA/INTERPSYCHIC
CONSUMER CHRONOLOGICAL									
CONSUMER MACRO/MICROSOCIAL	NS								
CONSUMER INTRA/INTERPSYCHIC	NS	NS							
REFERRAL CHRONOLOGICAL	.83	NS	NS						
REFERRAL MACRO/MICROSOCIAL	NS	.82	NS	NS					
REFERRAL INTRA/INTERPSYCHIC	NS	NS	.92	NS	NS				
PROVIDER CHRONOLOGICAL	.75	NS	NS	.73	NS	NS			
PROVIDER MACRO/MICROSOCIAL	NS	-.75	NS	NS	.79	NS	NS		
PROVIDER INTRA/INTERPSYCHIC	NS	NS	-.77	NS	NS	.89	NS	NS	

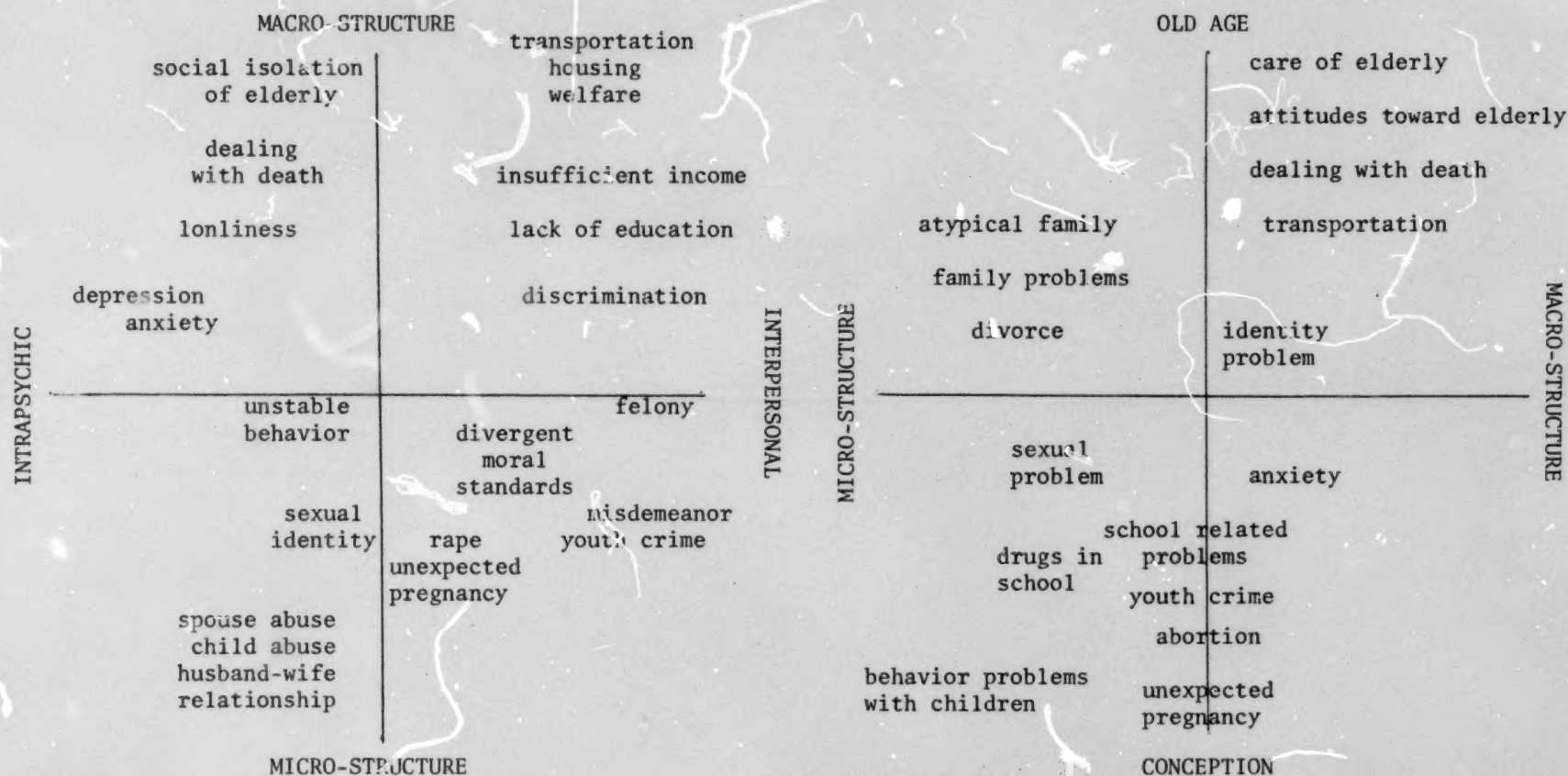


Figure 1. Three-dimensional individual difference scaling solution with dimension 1 (MACRO-STRUCTURE; MICRO-STRUCTURE) plotted by dimension 2 (INTRAPSYCHIC; INTERPERSONAL) on left side of figure and plot of dimension 1 by dimension 3 (OLD AGE; CONCEPTION) on right side of figure. Indicated in each plot are representative examples of problem issues.

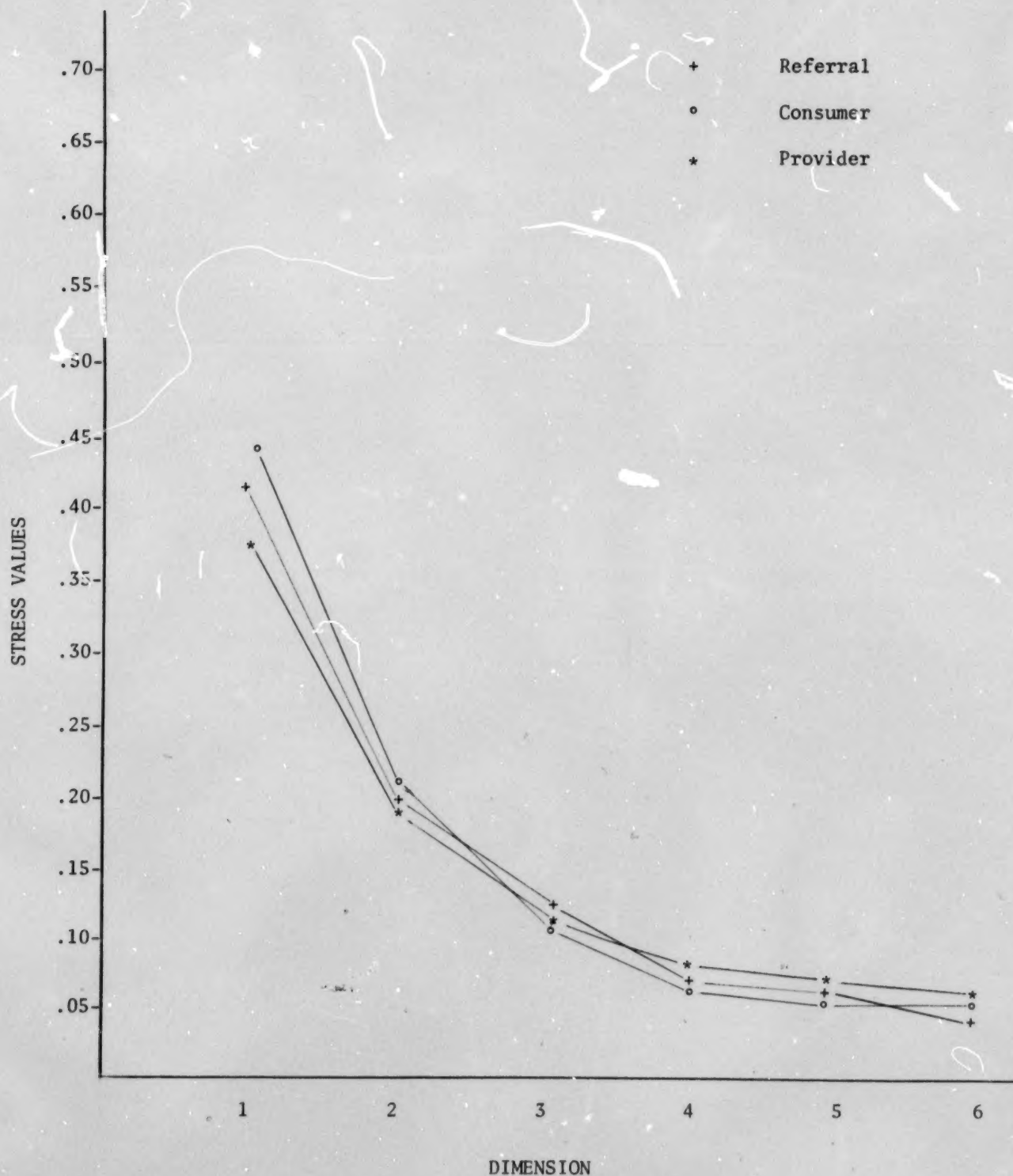


Figure 2. Stress values as a function of the number of stimulus dimensions for the multidimensional scaling of problems within each group.

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